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ABSTRACT

The contribution of school health programs to disease prevention among children and youth has included immunizations, screenings, referrals, and in some instances, treatment for potentially health-threatening conditions. State and community policymakers, as well as children and youth advocates, have been prompted to consider a broader role for school health services, due to poor health status of children, high risk behaviors, inadequate health insurance, poor health care utilization, and barriers to public health care. Policy planners believe that comprehensive school health programs can respond to the health information and preventive care needs unmet by society. Statistics are cited to reflect the poor health status and health-threatening behaviors of youth. The dearth of school health programs in the southern United States is attributed to inadequate funding, vocal opposition to school-based health services, and the autonomy of local school districts. States are urged to establish coherent and comprehensive state policy, support local determination of need, provide financial resources, monitor programs, evaluate programs, provide support services for school health personnel, and provide models of delivery. A table lists state regulations for health services in southern schools. Five models of state governments taking a leadership role in creating effective health services for school populations are briefly described. (JDD)

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BRINGING HEALTH TO SCHOOL:

Policy Implications for Southern States

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For the past 100 years, school health has been an integral part of the education system, created to support the learning process by "preventing, detecting, addressing, and resolving health problems; increasing educational achievement; and enhancing the quality of life."[1,2] More than just the "nurse down the hall", school health programs embody every health aspect of the education process: physical education, food services, school climate, health education, health promotion, guidance, counseling, and medical services. Each is a vital component of the school health framework and a valuable contributor to the wellness of school-aged children and youth.

The contribution of school health programs to disease prevention among children and youth, particularly through the health services component, has been enormous. Each year, millions of children receive in the school setting, immunizations, screenings, referrals, and in some instances, treatment, for a host of potentially health-threatening conditions.[3] The intent of school health services has always been to supplement rather than supplant the responsibility of the family for meeting the health care needs of children. Our changing social landscape has prompted state and community policymakers and children and youth advocates to consider a **broader** role for school health services. Consider:

Poor Health Status

Young people have long enjoyed good health, but that status is in danger: one out of five of today's 31 million adolescents has at least one serious health problem. Poor and minority teenagers are especially at risk, and there appear to be few resources for addressing their health needs[4] ●

High Risk Behaviors

Unlike disease-related entities of a century ago, today's threats to young people's health are largely attributable to lifestyle. High risk behaviors such as smoking, drinking, unprotected intercourse, and substance abuse—often initiated during adolescence—jeopardize the health and welfare of our young people; the consequences of these behaviors can have a lasting impact ●

Inadequate Health Insurance

A fair portion of our nation's youth face significant obstacles in receiving adequate and affordable health care. Nearly 20% (12 million) are without public or private health insurance. Among families that are poor or near-poor, have little education, and are minorities, the percentage of uninsured children is much greater.[5,6] Even those with insurance find that coverage for primary, routine preventive care is severely lacking ●

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Poor Health Care Utilization

Health care for young people is episodic and crisis-related, and opportunities for comprehensive preventive health screenings are scarce.[8] One in 12 of our nation's children do not have a regular source of health care. For black children, the rate is 1 in 5. Nearly one-quarter of inner-city children rely on "clinic care" through hospital outpatient services, emergency rooms, walk-in care centers, and public health centers.[9] For these children, a life-long pattern of emergency health care utilization is established ●

Additional Barriers to Public Health Care

Adolescent health providers, advocates, and policymakers in southern states report that poor health and poor health care utilization is exacerbated by a number of systemic factors: inadequate numbers of public health providers, inaccessible hours of operation, and a fragmented delivery system. Parental attitudes or perceptions that care is not needed also contribute to poor health care utilization. For young people seeking care on their own, lack of transportation, money, and information regarding available services are formidable barriers.

Regarding reproductive health care specifically, teens are reluctant to utilize services if they perceive a lack of confidentiality, if parental consent is required, or if the provider is insensitive to adolescents ●[10]

Schools as Health Providers

The challenge of addressing the health care needs of youth, argue many education and health policy planners, can be met by school health service programs. With its focus on health education, promotion, and screening, comprehensive school health programs can respond to the health information and preventive care needs unmet by society.

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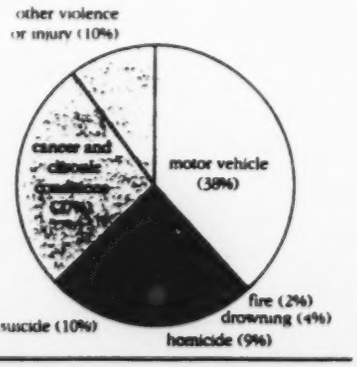
Youth at Risk

- A national adolescent health survey of high schoolers by the Centers for Disease Control revealed that 30% of adolescents smoke regularly, 35% surveyed tried marijuana, and 8% tried cocaine.[11] Within the past month, one third of all high school seniors engaged in heavy alcoholic drinking.[12]
- Reports of sexual activity among adolescents indicate that over 50% of young people are initiating sexual intercourse in their teenage years.[13]
- Teens, on the average, wait more than a year after initiating intercourse before they seek contraceptive providers, placing them at great risk for pregnancy or contracting sexually transmitted diseases.[14]
- Every year, 2.5 million teenagers become infected with sexually transmitted diseases.[15]
- Over one million adolescents become pregnant each year - a majority of which are unintended - and childbearing to adolescents has recently increased 10% among 15-17 year olds.[16]
- The mental health status of adolescents appears most troubling. An estimated 7.5 million (12%) of our nation's children suffer from mental disorders severe enough to warrant treatment.[17] National surveys of middle and high school students reveal an emotionally troubled adolescent population: 61% felt feelings of depression and hopelessness; 45% admitted trouble coping with stressful home and school situations; 36% reported having nothing to look forward to; 34% considered suicide; and 14% attempted suicide.[18] Every year, approximately 5,000 young people take their lives, three times the rate of twenty years ago.[19]
- A century ago, communicable diseases were the common killers of young people. Today, nearly three-quarters of the deaths to adolescents are due to social causes, many of which could have been prevented.[20]



The school's ability to reach children and youth disenfranchised from the health care system and at highest risk for poor health and potentially health-threatening behaviors is unmatched. The advantages are clear.

School health service programs:

- are equitable. They offer an entry point into the health care system for all children;
- can provide a broad range of comprehensive, preventive services not reimbursed by a majority of health insurance policies;
- are confidential;
- are user friendly. The services are provided in a trusting and familiar environment;
- are convenient! Teens are more likely to walk in spontaneously.[22]

A growing list of state and national organizations are recognizing the potential of school-based health services for enabling schools to contribute to healthy physical and emotional development, as well as intellectual development. The collaboration between schools and public health is gaining national attention through the efforts of the American School Health Association and the National Health/Education Consortium. Their leadership in the campaign to link public schools and health systems to achieve the synergistic goal of bringing young people into adulthood healthy, skilled, and productive gives tremendous political clout to a valuable program.

State government too has given much attention to school health services; the recommendation for comprehensive school health tops the list of nearly every state task force or strategic plan addressing the well-being of young people. Efforts to institutionalize these recommendations into policy have been the subject of legislative activity in many southern states. Education reform packages in Kentucky and Mississippi make specific recommendations for the inclusion of school health programs as a mechanism for achieving education goals ●

School Health in the South

Despite the recognition of school health services as an essential part of the prevention paradigm, the concept still is not universally embraced. In fact, the status of school health programs around the South seems as fragile as the health of those they are designed to serve. Many schools are plagued by inadequate health personnel and insufficient funds to adequately cover the myriad health needs of the school-aged population. Reports from school nurse consultants reveal that most schools across the region are not covered by the minimum standard of care — one school nurse per 750 students—adopted by professional health organizations. School health personnel are frequently shared among several schools and may be

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State Regulations for School Health Services

Alabama	No legal basis. [illegible] school nurses across the state. Nurse-student ratios range [illegible] Funded through federal Chapter One Special Education funds.
Arkansas	Each district shall have a health services program under the direction of a licensed nurse. [illegible] nurse-student ratio of 1:1,000. 46 school nurses state wide.
Delaware	State law mandates one school nurse per 40 teacher units (which may be approximately 1:500). A school district is entitled to at least one school nurse even if it contains less than 40 teacher units. Nurses are funded through state appropriations.
Florida	State law mandates school health programs to be coordinated through local education health agencies. $15.7 million of state revenue is awarded for basic school health projects. An additional $2.2 million was appropriated FY 1991-92 for expanded school health services.
Georgia	No legal basis.
Kentucky	Essential health services and screenings are required to be provided, but not exclusively by a registered nurse. [illegible] of all counties have school nurses.
Louisiana	No legal basis.
Maryland	Regulations require basic standards, but no mandate promulgated nor funded. Ratios varies 1:825 - 1:1,000. State Task Force on School Health offered recommendations for action at this time.
Mississippi	Legislature authorized State Department of Health to implement school nurse program but provided no funds or positions. Resources unavailable to put nurses where they're needed. Health agency has used creative mixture of Title XX, Title V and Title V cent dollars to fund school nurses, however such resources are currently unavailable.
Missouri	No legal basis. 75% of all counties don't employ nurses because of limited budgets. Bill pending to tax smokeless tobacco for school health programs.
N Carolina	State law authorizes but does not mandate school health program. Nurse-student ratios range from 1:600 - 1:8,000 students. State provides a guide, but very few mandates. State task force on elementary/middle school health recommended nurse-student ratios of 1:750. No action as of this date.
Oklahoma	Legal basis but no mandate.
S Carolina	No legal basis for programs. Ratios range from 1:2,000 to 1:15,000. 76% nurses state wide.
Tennessee	Tennessee Public School Nurse Code establishes priority for assignment of school nurses and sets one nurse per 5,000 students, but no less than one nurse per county wide system.
Texas	Essential school health services (screenings, health counseling, emergency care, communicable disease control) are required to be provided, but not exclusively by a registered nurse. The State Department of Education recommends one school nurse (registered nurse) per 1,000 students. Two thirds of the 1,056 districts, however, have less than 1,000 students in average daily membership.
Virginia	No legal basis. Essential screenings are required and districts are encouraged to establish school health advisory boards. Statewide nurse-student ratio found in 1985 study was 1:1,272 with great variation in student-nurse ratio among districts. Fourteen school districts have no school nurses.
W Virginia	State law mandates 1:1,500 nurse-student ratio and requires certification by state education agency. Nurses must be bachelor prepared. School nurses are funded through state appropriations and at the same salary scale as teachers.

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responsible for serving thousands of children. Nurse-student ratios range from 1:800 to 1:23,000 (see table). For many school health providers, crisis intervention is routine. Opportunities for primary preventive care and health promotion activities are limited.

The dearth of school health programs is attributed to three key factors, claim advocates and service providers from across the region: inadequate funding, vocal opposition to school-based health services, and the autonomy of local school districts.

- Funding for school health programs, by and large, is unstable. These programs rely on federal education monies for special-needs students or local education funds. The ancillary nature of school health services makes these programs a likely target for local budget cuts. Inadequate and inconsistent on-going financial support has made the maintenance and continued operation of school health services difficult.

- Opposition from a vocal minority has stymied school health expansion efforts across the region. Adversaries contend that school health programs undermine the parental responsibility for managing children's health care and misrepresent programs as contraceptive distributors. Dissemination of contraceptives, in fact, is rarely a part of school-based services; only 12% of clinics surveyed nationwide provide birth control on site.[23]

- State education agencies in most states across the South have little control over local education districts. This local autonomy is a great source of frustration for school health advocates: without incentives—or disincentives— from the state, or interest from local school administrators, standards and mandates are easily disregarded by unsympathetic districts ●

Toward More Effective State Policy

Considering the poor health of a growing number of children and youth, the fragile status of school health services, and the barriers to program implementation, states clearly must play a role in facilitating the development of school health programs at the local level. Leadership from state health, education, and mental health agencies is essential to assisting communities in identifying both needs and resources, educating local leaders about those needs, and cultivating broad-based support for on-site school health programs. To this end, states should:

Establish Coherent and Comprehensive State Policy

A comprehensive school health policy should be delineated at the state level which sets minimal standards of practice for all school districts and allows for and supports a wide range of school health programs that meet individual community needs. Such authorization should ensure that basic health services, such as screenings, health assessments, and counseling activities are provided in every school. Policy and program guidelines should be furnished to each local education agency with protocols for program operation and standards of procedure, including HIV and communicable disease policies, medication administration, and emergency transportation ●

Support Local Determination of Need

State education and health agencies should assist communities in assessing student health needs and developing programs to meet those needs. Health risk data, gathered through surveys and a review of local public health statistics, can be helpful in designing school health programs, as well as in enlisting the support of community members and policymakers. Such data is also useful in targeting high prevalence areas where, given limited resources, school health programs should be a priority.

Once school health needs are determined and program objectives have been established, states should assist local agencies in negotiating state policies and regulations which might interfere with implementation ●

Provide Financial Resources

A greater long-term commitment of resources, through a collaboration of state and local dollars, is necessary to finance school health programs and to provide health personnel salaries commensurate with other health professionals performing similar tasks in like settings. Several legislatures in the region have allotted state appropriations to support the development of school health services (see state models) ●

Monitor Programs

To ensure that state standards are being met in each school district, states should provide a mechanism for oversight and quality assurance. In many states, a school health nurse consultant coordinates local programs and related activities, assures local compliance, oversees peer review of school health providers, assists with program evaluation, and provides technical assistance for new programs ●

Evaluate Programs

States should prescribe measurable outcomes for school health programs and provide technical assistance for incorporating evaluation components to

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ensure that outcomes are met. Evaluation of school health service programs is critical as research on program impact has been extremely lacking. Data from school health service programs is needed to measure program outcomes, cost-effectiveness and cost-benefits, and to guide and direct public policy development, thereby providing the documentation necessary to maintaining political support for their operation ●

Provide Support Services for School Health Personnel

States should provide school health personnel with orientation, in-service training, and health-related resources and instructional materials (curricula, audio-visuals, pamphlets, etc.). The establishment of a state-supported network of providers can facilitate information exchange about successful programs and stimulate an internal support system among school health professionals ●

Provide Models of Delivery

States should provide schools with a menu of successful program models which can be adapted to community needs and resources. Certainly, not every school in each state can become the focal point for comprehensive physical health and mental health care services for all young people; many lack the financial resources and staff to accomplish such a task. The following three models, basic health, expanded health, and comprehensive health, are examples of program frameworks that can be adapted to schools based on financial and staffing resources ●

Schools as Health Screeners: Basic Health

Basic health services, the most common services model used in the region, perhaps the country, is the foundation of all school health programs (see table). Services are preventive in nature (screenings, assessments, counseling), typically delivered by a part-time health provider or school personnel trained to administer screenings. Emphasis is placed on the detection of health problems and referral to community health services for treatment.

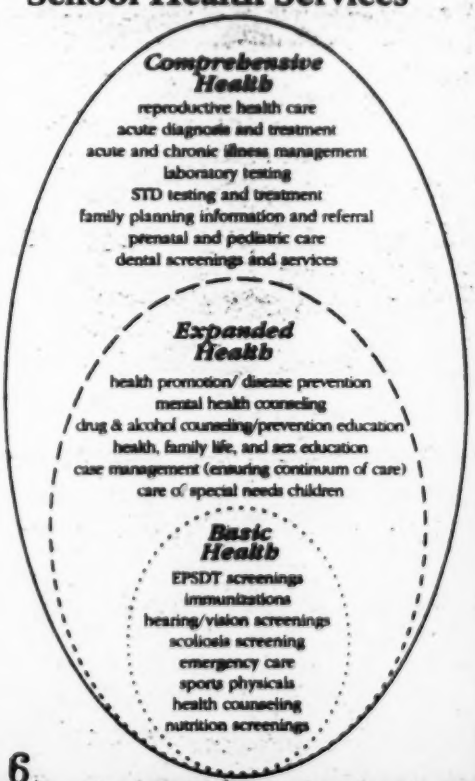
Schools as Community Brokers: Expanded Health

By building on a rudimentary school health services foundation, schools can extend the range of basic health screenings to include more accessible, comprehensive care for medically underserved students. This model typically employs a full-time health provider for one school or school district, or brings existing public health and mental health providers into the schools on a part-time basis. With health personnel on the school site for greater periods of time, more attention can be given to preventive education (in the classroom and in the clinic), managing students' health care, and linking families to community health services not provided on-site.

School as Principal Health Setting: Comprehensive Health

The school-based health center meets the broadest range of health needs. Services are comprehensive and selfcontained; testing, diagnosis, counseling and treatment are all part of the on-site services. Health personnel typically include a team of nurse practitioner, registered nurse, social worker, nutritionist, and supervising physician. Over 50 clinics have been established across the region, many in urban areas with high concentrations of low income, high-risk families. Reports from clinic administrators reveal that utilization of these school-based centers is extremely high. Frequently requested services include sports physicals, acute medical care, mental health counseling, and pregnancy testing. Physical appearance is of great concern to school-aged youth; health personnel provide weight loss and nutrition information, dermatological advice, and dental referrals (in some schools, dental screenings are available).

School Health Services



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There are obvious advantages and disadvantages to each model. Basic and expanded health care systems rely on follow-through and compliance with health care referrals and assume that the services are available and affordable to the family. In many instances, health personnel are not on the premises full-time and the range of services provided is limited due to the high nursestudent ratio. Additionally, school-based services are not generally available year-round, although a few do keep their doors open in the summer.

While the comprehensive school-based model is ideal, it is the most expensive of the three (the average operating budget is $150,000 annually) and is prone to controversy. The interest in school-based clinics and their possible impact on adolescent pregnancies has prompted opposition from parents concerned about family planning and abortion counseling on school property. For this reason, most clinics in the region do not dispense contraceptives and ALL school-based health programs require parental consent prior to student treatment. The controversial nature of comprehensive school health programs has prevented many states from supporting those schools that provide such services with state funds, or endorsing the expansion of successful models in other communities. Consequently, private foundations and health organizations have been the mainstay of financial and human resources support ●

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State Policy Models

The following are excellent models of state governments taking a leadership role in creating effective health services for their school populations.

WEST VIRGINIA: Mandating School Health Services

Each county school board is required by law to provide one school nurse for every 1500 students. State regulations further require that school nurses be registered professional nurses certified through the state Department of Instruction. Funding for school nurses is appropriated through the state, with salaries commensurate with those of other professional education staff.

Contact: Lenore Zedosky, West Virginia Student Support Services 314/348-8830

FLORIDA: Creative Funding for School Health Services

Florida's proposal for expanded school health programs included a price tag that nearly prohibited its implementation. By repealing a sales tax exemption on physical fitness club memberships, the state was able to forecast an additional $5 million to fund school health initiatives, with an anticipated $9.6 million for 1991-92 projects. School districts are provided a menu of school heath models that can be adopted, including health service teams and comprehensive health centers.

Contact: Josephine Newton, Florida Department of Education 904/488-8974

GEORGIA: Making Adolescent Health a Priority

The state Department of Human Resources declared the health of adolescents a priority for the state, and backed its commitment with a $1 million appropriation from federal block grants to local health agencies. The department's objective was to provide incentives to local school boards for establishing school health programs. By building partnerships between the local health, mental health, and education agencies, the united parties could receive grants for expanded school health services. Grants fund a health service team available to county school systems. Additional private funds are being sought to expand the collaborative effort among community youth-serving agencies across the state.

Contact: Becky Winslow, Georgia Office of Adolescent Health 404/894-7505

DELAWARE: Legislative Commitment to School Health Services

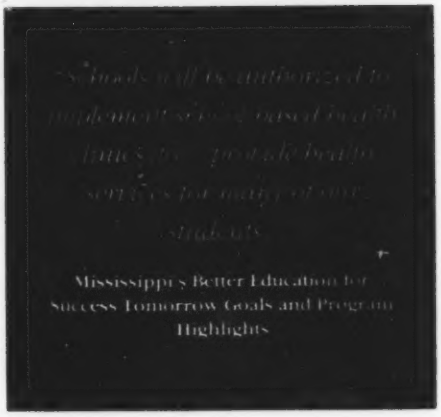
The Delaware Legislature's support for school-based wellness centers is demonstrated through the state budget process. Since 1986, the four school-based demonstration projects have each received $100,000 annually. A ground swell of support since the initiation of the wellness centers has helped to maintain a significant level of funding, even in fiscally-tight years. New start-up funds will be made available through the legislature for additional schoolbased health projects via grants-in-aid not to exceed $50,000 and requiring a local match for the balance of funds.

Contact: Rachel Yoskowitz, Delaware Office of Adolescent Health 302/739-4785

ARKANSAS: Giving a Voice to School Health

The State Health Officer Dr. Joycelyn Elders is a champion of school health services, not just in Arkansas, but across the country. Using her position of leadership, she has given the issue enormous visibility, and in little over four years, has brought public health services into 21 of 75 counties and 48 schools across Arkansas. Public health officials should play a pivotal role in health promotion, decision-making, disease prevention, and treatment through school-based health education and services programs, argues Elders. At the invitation of local school boards, public health nurses now come into the schools on a regular basis providing screenings, counseling, and immunizations. Schools provide the space and the health department provides the rest.

Contact: Missy Fowler, Division of Child and Adolescent Health 501/661-2241



Conclusion

The changing health status of our nation's young people demands a rethinking of the way in which health services are delivered to them. Schools appear best poised to provide for the multitude of physical and mental health needs to those most likely to be disconnected from traditional health providers. With its broad focus on education, counseling, and services, school health programs not only cater to those needs, but augment the community's capacity to address substance abuse, child abuse, AIDS and other sexually transmitted diseases, adolescent pregnancy, and suicide prevention as well. Many schools in the South are only beginning to provide a base of preventive health services. Others are expanding the school walls even farther to address difficult health issues like pregnancy, drug and alcohol abuse, and mental stress. The aforementioned examples of leadership in this report indicate that change is occurring, and can occur. But necessary to that change is a partnership of vision, leadership, funding, and determination to expand traditional boundaries and forge collaborations to meet the goal of a healthier youth ●

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